Arizona Department of Insurance
2910 North 44th Street, Suite 210
Pheonix, Arizona 85018-7256
www.state.az.us/id
602.912.8400

Arizona Department Of Insurance

HEALTH CARE APPEALS ANNUAL REPORT

For the Fiscal Year Ending
June 30, 2001

Charles R. Cohen
Director of Insurance
To

The Honorable Jane Dee Hull
Governor

The Honorable Randall Gnant
Senate President

The Honorable Jim Weiers
Speaker of the House

HEALTH CARE APPEALS ANNUAL REPORT

Introduction

This is the fourth annual report on the activities of the Health Care Appeals Unit, part of the Consumer Affairs Division of the Arizona Department of Insurance (the "Department"). Established in 1998, the Health Care Appeals Unit administers the 1997 legislation which created a process for Arizona health insurance consumers to appeal denied claims and denied requests for health care services. The appeal process culminates in an opportunity for an insured to obtain external review, an unbiased, independent level of review administered by the Department.

Contents

This report is prepared pursuant to A.R.S. §20-2531 which requires the Department to annually report the number of requests for external independent review, including the number of requests involving questions of coverage, the number involving medical necessity, the number of requests referred by the Department for external review and the results of those reviews.

Importance of State Regulation of External Review Programs

Enacted in 1997[1] and effective July 1, 1998, the Arizona health care appeals process was one of the earliest state-mandated dispute resolution mechanisms of its kind. To date, 40 states and the District of Columbia have enacted some form of external review laws.[2] Although the laws vary considerably among states, Arizona's health care appeals process remains broader in scope than many others. For instance, in Arizona not only health maintenance organizations (HMOs), but also traditional indemnity insurers, prepaid dental and vision plans, and non-profit hospital, dental and optometric service corporations are all required to provide an appeals process to their insured members. Additionally, whereas the majority of state external review laws apply only to denials based on medical necessity, Arizona's law permits both medical necessity and coverage-based denials (those based on contractual terms) to be appealed. Other features that make the Arizona law expansive in scope and availability are a generous two-year time frame within which to initiate the appeal process, no imposition of a dollar amount threshold for the service or claim at issue, and no imposition of fees on the consumer to initiate an appeal.

[1] Senate Bill 1098

[2] Kaiser Family Foundation and Georgetown University Institute for Health Care Research and Policy, *External Review of Health Plan Decisions: An Update,* (forthcoming, Dec. 2001).

In 2001, the Department assumed new responsibilities with regard to oversight of provider payment and the health care delivery systems of managed care and pre-paid dental plans. Although preceding in time these emerging areas of regulatory oversight, the health care appeals process provides an integral component of effective quality of health care regulation. When fully operational, each facet of health insurance regulation that is now centralized under one agency, will synergize with the others. Thus, the effectiveness of an insurer's health service delivery system (e.g. the adequacy of a health care network, timely access to specialists, prompt payment to providers, mandated benefits) can often be identified through the actual experience of individual consumers reflected via the health care appeals process. This ability to monitor compliance nearly contemporaneously with the delivery of service, is a great advantage of comprehensive state regulation.

As the United States Congress considers legislation commonly referred to as the "Patient's Bill of Rights" which would, among other provisions, create a federal right to external review,[3] consideration must be given to the threat such a federal mandate could pose to an effective state health care appeals program.

Generally, federal legislation which seeks to establish "federal floors" that states must meet in the design of an appeal and external review program do not threaten the effectiveness of state based appeals programs. However, federal legislation which would preempt existing and effective state regulation and administration of health care appeals and external review could be detrimental to health insurance consumers. The ability of our local legislators and state executive branch to continue to make policy with respect to health care insurance issues which are unique to the Arizona market is very valuable to Arizona's health insurance consumers. Moreover, the fact that the health care appeals process in Arizona is part of a comprehensive, interdependent, and increasingly effective state oversight program, must be protected. Should the external review program be preempted in whole or in part by federal legislation, the State could lose its ability to closely monitor and swiftly correct areas of insurer noncompliance. Because there is no particular federal agency charged with policing health care insurers and monitoring the work of independent review panels, work that the Department is now effectively performing to ensure consumer protection could be replaced by a void.

[3] On June 29, 2001, the Senate passed S. 1052, and the House of Representatives passed H.R. 2563 on August 6, 2001. Although both bills contain provisions governing internal and external review of health care denials, only the Senate bill allow states to retain such laws by certifying "substantial compliance" with the federal law. Amendments included in the House bill would preempt all state internal and external review processes.

Arizona's Health Care Appeals Process

The Structure

In general, the health care appeals law[4] provides a three-tiered process for insured members to contest denials of claims or requests for service.

- **A denied "claim"** occurs when a person has already received care, submitted a claim for payment, and the insurer refuses to pay all or any portion of the claim.

- **A denied "service"** occurs when a person has requested a health care service or a referral to a specialist and the insurer refuses to pre-authorize the service. Thus, the desired service has not yet been rendered.

Exemptions to Arizona's Health Care Appeals Law

- Federal plans
- Worker's Compensation policies
- Self-funded employee benefit plans
- Fixed benefit plans (when benefit is based on the "health status of the insured")
- Long Term Care policies
- Medicare Supplement policies

A denied "service" not yet rendered may be eligible for an expedited appeal process if the insured member's treating provider submits a written certification along with supporting medical documentation indicating that the time required for the standard appeals process "is likely to cause a significant negative change in the member's medical condition" which is at issue in the appeal. If the denial of services does not meet this threshold, or the provider does not submit the required certification, the appeal will move along the standard track. All denied claims fall under the standard process, as they cannot be reviewed as expedited appeals.

	Standard Process	Expedited Process
Level 1	Informal Reconsideration	Expedited Medical Review
Level 2	Formal Appeal	Expedited Appeal
Level 3	External Independent Review	Expedited External Independent Review

Thus, the majority of appeals follow the standard appeals track. Denied requests for service begin at the Informal Reconsideration level. Denied claims may begin at either the Informal Reconsideration level or at the Formal Appeal level, depending upon the manner in which the insurer has structured its internal appeal process. The insurer's health care appeals information packet should be consulted to determine where denied claims originate.

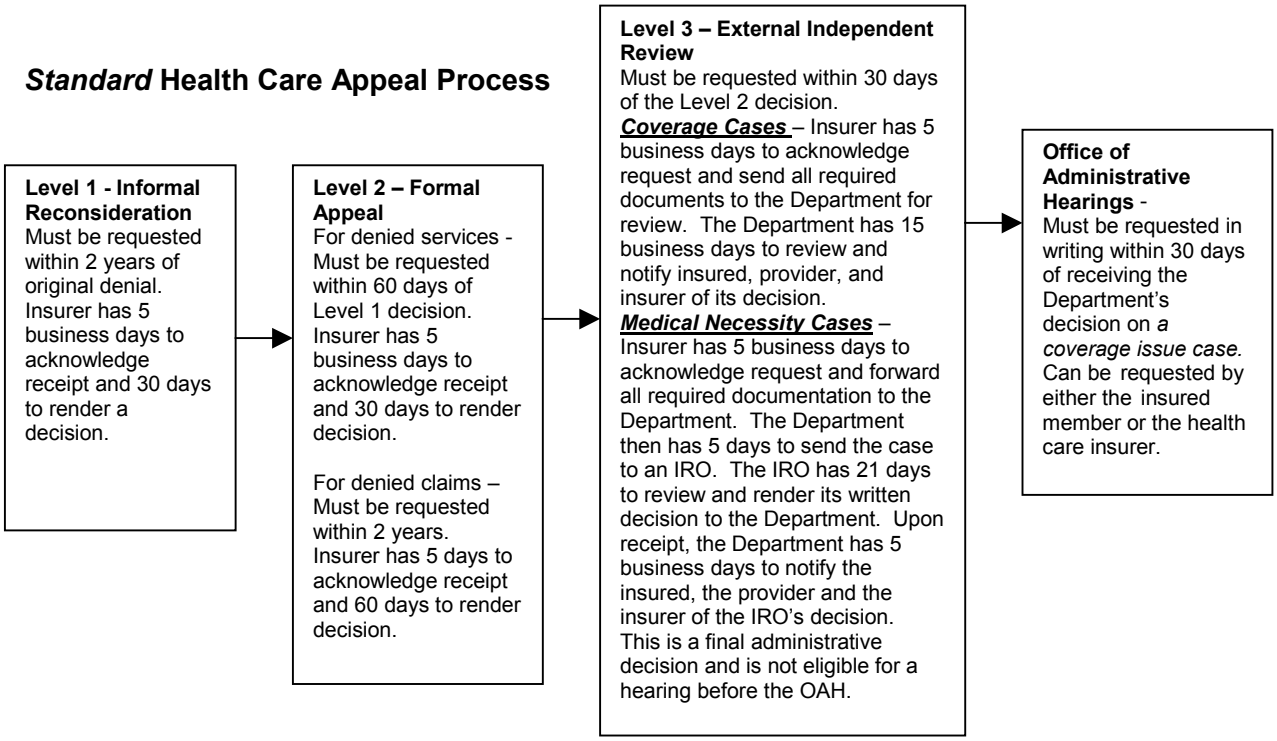
The insured member must exhaust the insurer's internal appeal steps before requesting external independent review. However, an insurer may choose to accelerate a case to external review at any of the internal levels.

Who can request an appeal?
- the insured member
- the member's treating provider
- parent, if a minor
- legal guardian
- person authorized to make decisions by a power of attorney

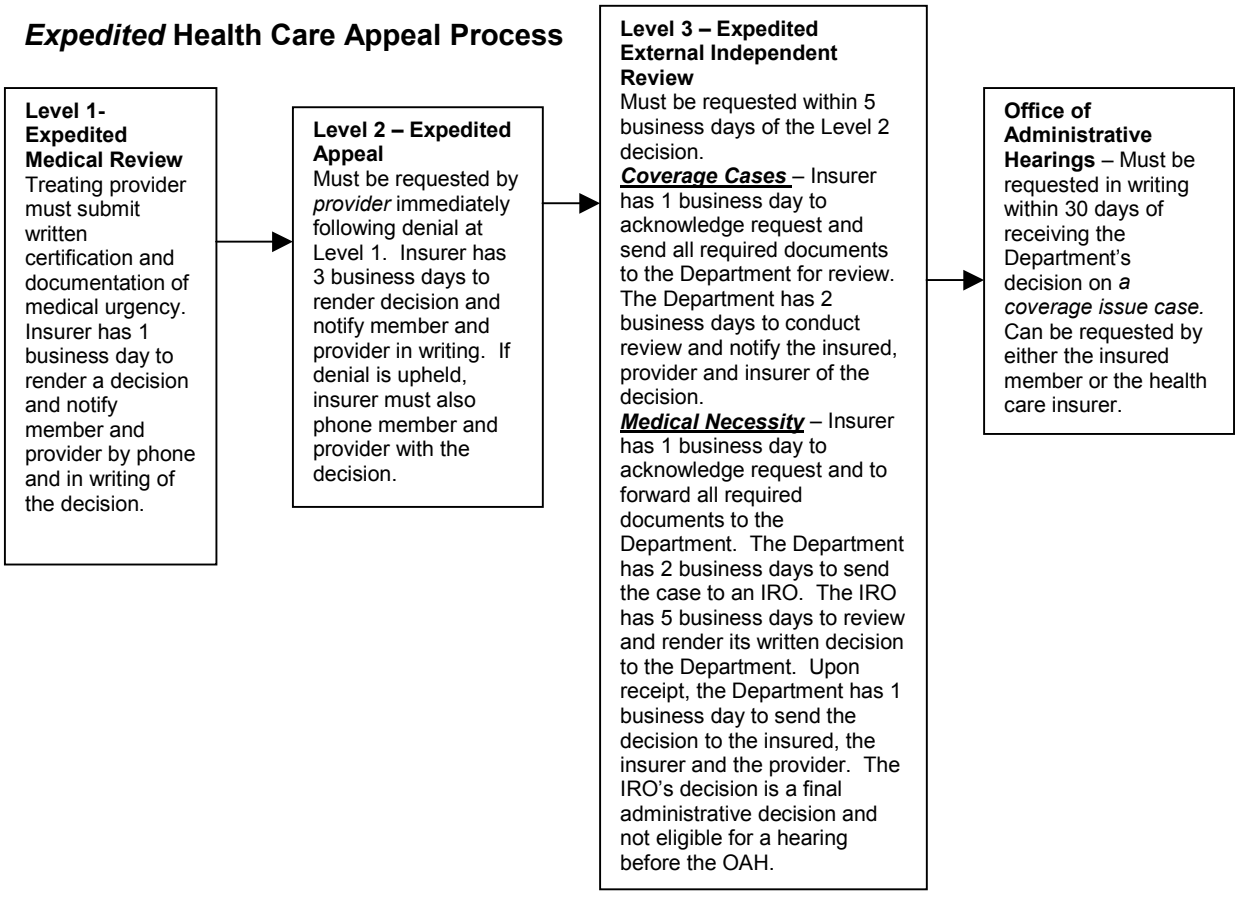
[4] A.R.S. §§20-2530 through 20-2541.

The following flow charts graphically represent the two separate tracks available for health care appeals, as well as the time frames for review at each of the three levels.

Standard Health Care Appeal Process



Expedited Health Care Appeal Process



The Department's Administration of the External Level of Review

The health care appeals law has continued to evolve through legislative amendments since its passage in 1997. Very significant changes became effective March 1, 2001. Since independence is the hallmark of an appropriate program of external review, the process was revised to require the Department to procure the services of Independent Review Organizations (IROs) for cases involving medical issues. Prior to March 1, 2001, a health care insurer chose a medical reviewer from a list compiled by the ADOI, then directly submitted the case to the reviewer, negotiating the cost of the review and paying it directly. Under the revised process, the insurer sends the case to the Department which then chooses a reviewer from a list of contracted IROs. The Department sends the case to the selected IRO and, upon completion of its review, the IRO sends its decision back to the Department which has the responsibility of notifying all parties of the final determination. Thus, the health care insurer has no direct relationship or contact with the chosen reviewer at any time during the review.

Nor does the insurer directly pay the IRO for medical reviews under the revised law. Pursuant to Senate Bill 1330, in 2001 the Department created a revolving fund from which it pays the IRO and then bills the health care insurer on a per-case basis. The insurer's remittance then reimburses the revolving fund.

The State Procurement Office awarded contracts to six IROs for one year with a renewal option for the following four years. Each organization was required to submit bids based on a per-case rate for standard reviews and a per-case rate for expedited reviews. The law also provides protections to which each IRO must adhere in order to insure a fair and impartial decision. For each medical case the Department submits to an IRO, it requires that the organization research and certify that neither the organization nor the individual reviewer have a substantial interest in the insurer at issue. Additionally, the individual medical reviewer assigned to a particular case cannot be a policyholder of the insurer under review.

Contracted IROs during 2001:

- CarePoint Analytics, Inc. (dba Permedion)
- CORE, Inc.
- Hayes Plus, Inc.
- Health Services Advisory Group
- Maximus, Inc. (dba Center for Health Dispute Resolution)
- Prest & Associates, Inc.

Although the Department had not detected any actual bias or impropriety under the former structure, the revised process under which the Department administers all facets of external review, certainly strengthens the independence of the appeals process and fosters increased consumer confidence by eliminating the perception of potential bias inherent in allowing an insurer to choose and compensate its own reviewer. Since the revised process was only in effect for three months of this reporting period, it is premature to draw any conclusions about the overall impact on case dispositions.

Being Informed … Notification Requirements

Critical to the effectiveness of the health care appeals law is the consumer's awareness that such a process exists. Built into the law are several points at which notification of the right to request an appeal is triggered. Paramount among these is the insurer's obligation to distribute a health care appeals information packet. The information packet is a form which must be approved by the Department of Insurance in advance of distribution. A.R.S. §20-2533(C) requires health care insurers to provide insured members with a separate appeals information packet at the time coverage begins. A packet must also be provided to the insured within 5 business days of an initial request for an appeal. Additionally, at any time, a packet must be provided to the insured or a treating provider upon request.

To further assure a health insurance consumer's awareness of the appeal process, the law was amended last year to require insurers, at the time of each denial, to inform the insured about the right to appeal. The provision requires that such notice be prominently displayed on the Explanation of Benefits or similar document. This addition to the law recognizes that the most important time at which an insured should be aware of the right to appeal is at the time of a denial.

Insurers are also required, upon annual policy renewal, to mail a separate notice to insured members that reminds them about the appeals process and that they can obtain a replacement appeals information packet upon request.

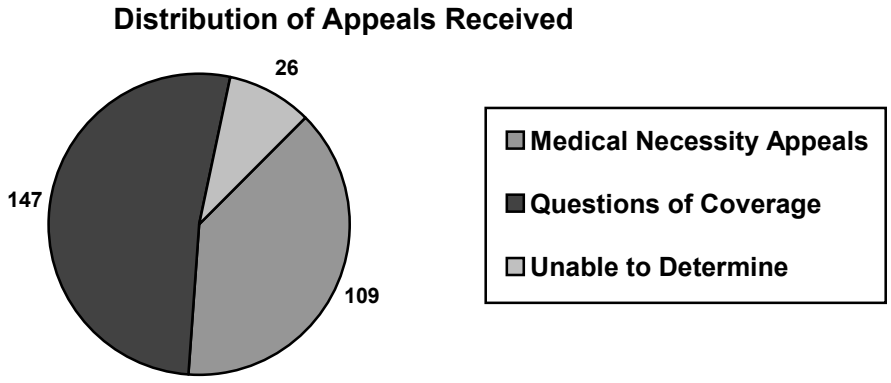
Another amendment to the law required the Department to create a standard appeal request form that insurers must include in their appeals information packet. Although an insurer may not require the insured to use the form when pursuing an appeal, it does provide a useful guide for those consumers unsure of the information needed to initiate their request. This form, as well as a provider certification form for expedited appeals and a consumer brochure explaining the appeals process, are available on the Department's website at www.state.az.us/id.

For more detailed information on the health care appeals process in Arizona, please refer to the following publications on the Department's website at www.state.az.us/id

➔ *A Consumer's Guide to Health Care Appeals* (under "Publications")
➔ Regulatory Bulletin 2001-10
➔ Regulatory Bulletin 2000-13

Statistics for Fiscal Year 2001 (July 1, 2000 to June 30, 2001)[5]

Summary of External Independent Reviews



Here is a breakdown of the disposition in the 282 external review cases processed from July 1, 2000 through June 30, 2001:

Of the 147 cases that ADOI has directly reviewed as Questions of Coverage:

118	upheld
8	overturned
4	partially upheld/partially overturned
2	remain pending
2	health care insurer overturned prior to ADOI decision
13	rejected by the Appeals Section of ADOI because they did not meet the statutory definition of an appealable issue or were withdrawn voluntarily by the insurer

Of the 26 cases ADOI received as coverage issues but directed to an IRO:

14	upheld
11	overturned
1	remains pending

[5] Please note that the following figures have been reported on a fiscal year basis. For administrative reasons, the Department has changed the reporting time frame of this report to the most recently completed state fiscal year. Since the 2000 report was on a calendar year basis, this results in the duplication of cases reported for the time period of July 1, 2000 through December 31, 2000.

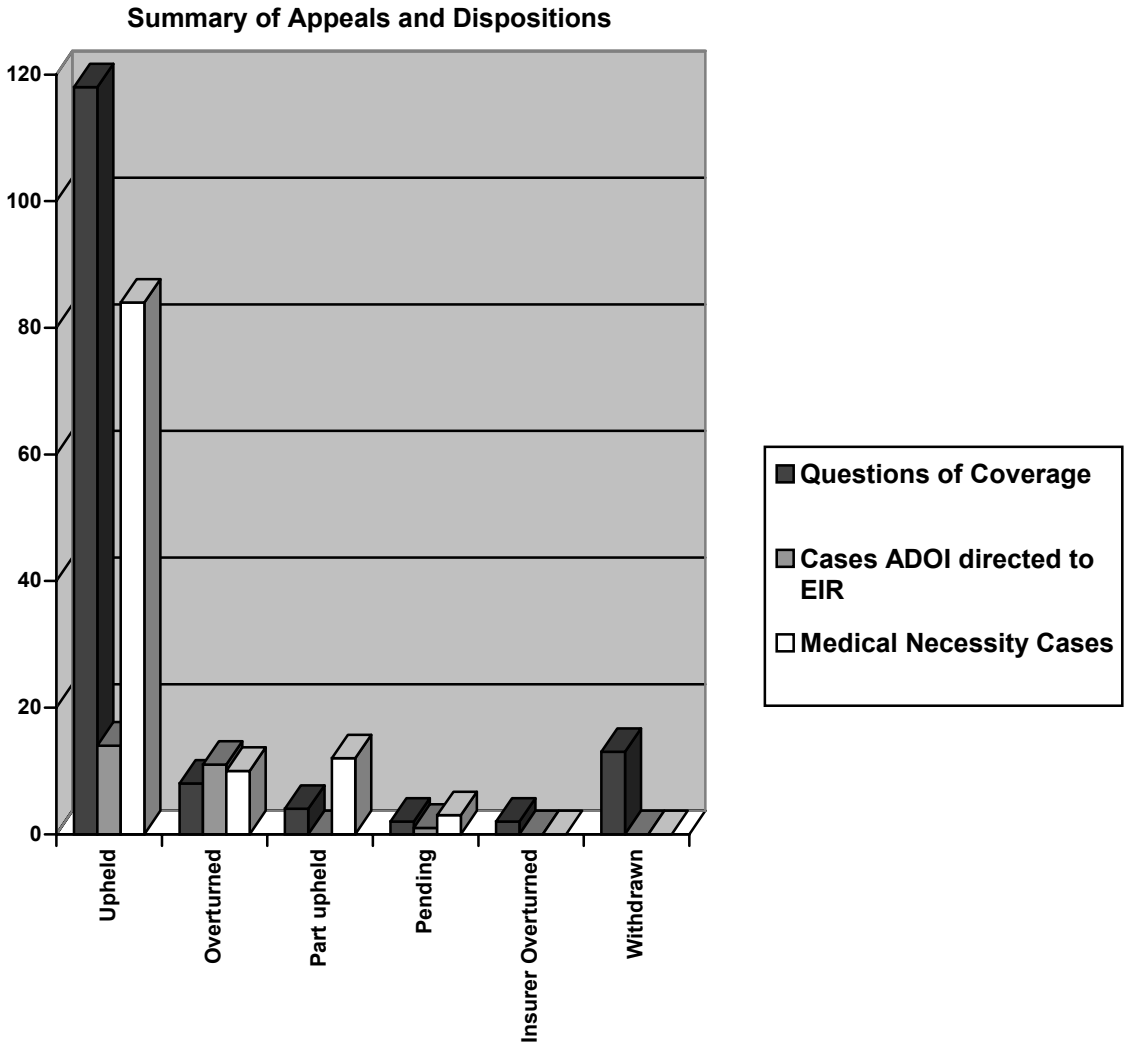
Of the 109 cases sent directly to an IRO for medical review:

84 upheld

10 overturned

12 partially upheld/partially overturned

3 remain pending



Summary of Insurer Internal Appeals

The Department has annually surveyed the health care insurers operating in Arizona to determine appeals activity at the levels of the process performed within the health plan. Although the figures are self-reported by insurers, they

are a critical component in evaluating the overall effectiveness of the health care appeals law.

Since its inception, the survey data has been reported on a fiscal year basis. In this regard, it is instructive to compare the two prior years. The figures demonstrate that over 50% of Informal Reconsideration appeals and nearly 60% of Formal Appeals are being overturned in favor of the health care consumer. This rate of reversal is perhaps the strongest indication that the original intent of the appeals law is being realized.

	Number of Expedited Medical Reviews	Percentage of Expedited Medical Reviews Overturned	Number of Expedited Appeals	Perctage of Expedited Appeals Overturned	Number of Informal Reconsideration Appeals	Percentage of Informal Reconsideration Appeals Overturned	Number of Formal Appeals	Percentage of Formal Appeals Overturned
FY 2001	**155**	**37%**	**38**	**37%**	**8,000**	**54%**	**2,724**	**59%**
FY 2000	248	41%	N/A	N/A	8,025	59%	2,744	50%
FY 1999	459	21%	N/A	N/A	5,897	44%	1,936	49%

Summary of Appeals to the Office of Administrative Hearings

Following a coverage determination by the Department of Insurance, the nonprevailing party, either the insured person or the health care insurer, may request a hearing with the Office of Administrative Hearings (OAH) to review the decision. Although the Department is not a party at this ultimate level of review, it has tracked the disposition of cases which have appeared before the OAH.

Total number of requests for hearing From July 1, 2000 through June 30, 2001:	28
Number of cases which were vacated, Dismissed, or settled prior to hearing:	8
Number of cases in which OAH upheld The Department's decision:	14
Number of cases in which OAH reversed The Department's decision:	0
Number of cases which were still pending With OAH at fiscal year end:	6

Even when a review by the OAH of the Department's decision is requested, oftentimes the parties reach an interim settlement prior to a final hearing. The hearing may also be vacated or dismissed for failure of the appellant to appear.

In the 14 cases which reached an OAH hearing, the Department's determination was upheld in all 14 cases.

Enforcement Activities. . . Targeted Audits

To oversee insurer compliance with this important consumer right, the Department has designated staff to conduct targeted desk audits of health care insurer's appeals files and written procedures. At the fiscal year end, 12 audits had been conducted with 10 completed, resulting in corrective orders and the imposition of civil penalties totaling $100,000.

The Department plans to continue and expand this important enforcement subprogram in the coming year. Health care appeal compliance is also reviewed during general market conduct examinations of insurers

Common Insurer Deficiencies

- Failure to distribute information packets
- Rejecting appeal requests that originate with a provider
- Failure to render internal appeal decisions within the statutory timeframe
- Processing appeals differently in practice that the manner described in the information packet
- Failure to provide criteria and clinical reasons which explain decisions

Conclusions

- The Department already has strong, interdependent programs designed to monitor quality health care delivery by health insurers in Arizona. The effectiveness of the health care appeals program could be threatened or, at the least, fragmented, by passage of a Federal Patient's Bill of Rights which would preempt state law in this area.
- In early 2001, the Department successfully transitioned the medical review component of external review to the new process involving contracted IROs and, Departmental administration of the process, thus safeguarding the "independence" of the external level of the appeal process.
- Although the percentage of cases overturned at the external review level has decreased since the inception of the program, the rate at which internal appeals are overturned has steadily increased. One possible explanation is that the existence of an external level of review outside the insurer's involvement, creates incentive for health care insurers to carefully review appeals at the internal levels of review.
- Targeted appeals audits continue to uncover insurer deficiencies in the appeal process for which the Department is able to swiftly administer corrective and punitive action.
- A health care insurance consumer's awareness of the right to challenge an insurer's denial remains the most important facet of an effective program. Several amendments to the law have enhanced notification requirements to ensure the consumer is apprised of the right to appeal at the most opportune time, and the Department will continue outreach efforts to the public in general.

Please contact our Americans with Disabilities Act (ADA) Coordinator at 602.912.8456 if you need reasonable accommodations due to a disability with regard to this publication or other services of the Department of Insurance. Requests should be made as early as possible to allow reasonable time to make necessary arrangements to obtain materials in an alternate format.

Published December 2001
Arizona Department of Insurance